VACCINE ADMINISTRATION RECORD

1. Complete the highlighted areas below – *Please Print Clearly*

Name: _____ **Telephone**: _____
LAST NAME FIRST NAME MI

Date of Birth: _____ **Age**: _____ **Gender**: ☐ Female ☐ Male

Town of Residence: _____

Mailing Address: _____
P.O. BOX OR RR TOWN STATE ZIP

Island Physician or Clinic: _____

I am not allergic to chicken eggs, chicken, chicken feathers or dander; I am not allergic to Thimerosal (a mercury-based preservative); I do not have a history of severe allergic reactions to vaccines.

_____ Date: _____
Signature of person receiving the vaccine or that person's parent/legal guardian if under 18

CONSENT FOR CHILD'S VACCINATION:
I have read or had explained to me the 2013-2014 Inactivated Influenza Vaccine Information Statement and understand the risks and benefits. I give consent for my child named on this form to get vaccinated with this vaccine. Children under the age of 18 will not be vaccinated without this signed consent.

_____ Date:_____
Parent/Legal Guardian's Signature

2. Complete this section if you are covered by Medicare Part B or other insurance and sign again below.

Medicare Number: _____ Part B? ☐ YES ☐ NO

Other Insurance:_____ **Policy Number:**_____

I give permission for this agency and/or the Massachusetts Department of Public Health to bill Medicare Part B or my other insurance carrier on my behalf for influenza vaccine.

_____ Date: _____
Your Signature

Please complete the Questionnaire on back ➜

Below this Line for Clinic Use Only

Vaccine	Type of Vaccine	Date given mo/da/yr	Dose	Route	Site* RA - LA RT - LT	Vaccine		Information Statement		Vaccine Admin. Initials
						Lot # Exp. Date	Mfr	Date on VIS	Date Given	
Influenza	**Flu**		**0.5ml**	**IM**				**7/26/13 -English 7/2/12 -Portugeuse**		

	Signature of Vaccine Administrator

* Site given: RA = Right Arm, LA = Left Arm, RT = Right Thigh, LT = Left Thigh.

This Immunization record will be retained by Vineyard Nursing Association ◆ (508)693-6184